Nebraska's Aging and Disability Resource Center

Dann Miln of Health Policy Consulting prepared a report, dated March 10, 2010, for the Centers for Medicare and Medicaid Services under a contract with Ascellon Corporation for Money Follows the Person project technical assistance activities.

The report shared findings from eight states that volunteered to be part of an MDS 3.0 pilot study in 2008. Appendix 2 of the study, Return to the Community Referral Care Area Trigger Summary, included a checklist for nursing facilities' review of Return to Community referrals.

As written in the report, "The views expressed in this report are those of the researcher and correspondents and do not necessarily reflect those of the Centers for Medicare and Medicaid Services or project officers."

Appendix 2 from the study follows:

Appendix 2

RETURN TO THE COMMUNITY REFERRAL
Care Area Trigger Summary

INTRODUCTION

Triggers identify residents who have or are at risk for developing specific functional problems and require further evaluation. A care area trigger (CAT) provides a starting point for the facilities to perform care planning and should be used in combination with other care planning information. This optional protocol provides guidelines embedded in checklists and an analysis of findings section, which were developed under CMS contracts. Alternatively, a facility may identify its own care planning protocols and tools for residents and their families based on their experience with existing care planning approaches and software, identify evidence based research protocols and tools, work with experts or software vendors to create customized care planning systems, utilize an integrated electronic medical record (EMR) data systems, etc. Chapter 4 of the Resident Assessment Instrument Manual discusses the minimum data set (MDS) triggering mechanism, defines CAT triggers and linking the assessment to the care plan.

This CAT Return to the Community Referral summary focuses on residents who want to talk to someone about returning to the community. The CAT triggers include: the resident goal that he/she expects to be discharged to the community (Item Q0300A1); the resident and care planning team determine discharge to the community is feasible (Item Q0400B1); and the resident (or their family or significant other if resident is unable to respond) wants to speak to someone about the possibility of returning to the community (Item Q0500B1). All individuals have the right to choose the services they receive and the settings in which they receive those services. This right became law under the Americans with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the Olmstead vs. L.C. decision in 1999. The ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments have a responsibility to enforce and support these choices. An individual in a nursing home can choose to leave the facility at any time. An individual can request to talk to someone about returning to the community at any time. The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives. The discharge planning goal of nursing home care is to assist the individual in maintaining or achieving the highest level of functioning. This includes ensuring that the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors, implementing comprehensive plan of care interventions, interdisciplinary coordination, fostering independent functioning, using rehabilitative programs, and community referrals.

Expectations about returning to community living are unique for each individual. An individual may expect to return to his or her former home or return to a different community home, or the individual may identify a desire to stay in the nursing home. Each person's level of understanding about his or her health status and needs for physical assistance as well as the

availability of family and other supports also varies. This CAT summary enables the facility staff to directly open the discussion about the individual's preferences for service settings.

When the Return to Community Referral CAT is triggered, this summary helps assess the situation and begin appropriate care planning, discharge planning, and other follow-up measures. The goal is to initiate and maintain collaboration between the nursing facility and the local contact agency to support the individual's expressed interest in being transitioned to community living. This includes facility support for the individual in achieving his or her highest level of functioning and the involvement of the designated contact agency providing informed choices for community living. This collaboration will enable the State-designated local contact agency to initiate communication by telephone or visit with the individual (and his or her family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.

Return to Community Referral Follow-up

Step 1: Follow the items below to assist with the individual's stated desire to return to community living. Step 2: Check the box in the left column when the item has been completed. Step 3: Analyze your findings in the context of further follow-up required for this individual. Step 4: Communicate findings and concerns to the physician.

Review of Return to Community Referral

✓ **Steps in the Process**

☐	1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not.
☐	2. Interview the individual and his or her family to identify potential barriers to transition planning. The care planning/discharge planning team should have additional discussions with the individual and family to develop information that will support the individual's smooth transition to community living.
☐	3. Other factors to consider regarding the individual's discharge assessment and planning for community supports include: • Cognitive skills for decision making (C1000) and Cognitive deficits (C0500, C0700-C1100) • Functional/mobility (G0110) or balance (G0300) problems
☐	4. Inform the discharge planning team and other facility staff of the individual's choice.
☐	5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual's overall goals of care from a previous Item Q0300 response. Has the individual indicated that his or her goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home after rehabilitation in your facility?
☐	6. Initiate contact with the State-designated local contact agency within 10 business days.
☐	7. If the local contact agency does not contact the individual by telephone or in person within 10 business days, make another follow-up call to the designated local contact agency as necessary.
☐	8. Communicate and collaborate with the State-designated local contact agency on the discharge process. Identify and address challenges and barriers facing the individual in their discharge process. Develop solutions to these challenges in the discharge/transition plan.
☐	9. Communicate findings and concerns with the facility discharge planning team, the individual's support circle, the individual's physician and the local contact agency in order to facilitate discharge/transition planning.

Return to Community Referral Follow-up

Analysis of Findings
Conclusions about return to the community for this individual:
Factors that complicate the situation for this individual:
Risks for this individual related to these findings:
Referrals to other health professionals or community entities related to return to the community: